Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NISAL CORP
PO BOX 24809
HOUSTON TX 77029

Respondent Name

LIBERTY MUTUAL FIRE INSURANCE

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-12-0097-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Upon further review we have noted that the correct pre authorization number has been located in the appropriate box on the cms-1500 since it's initial faxing on 5/24/11."

Amount in Dispute: $78.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The billed charges for 05/04/11 for procedure code 97124 and 97032 were denied correctly as not pre-authorized. The only procedure codes approved by our Utilization Management department are 97110, 97112 and 97140."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, GA 30504

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 4, 2011	Physical Therapy Services – CPT Codes 97124 and 97032	$78.00	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated July 29, 2011

- 197, X170-Pre-authorization was required, but not requested ofr this service per DWC Rule 134.600.

Explanation of benefits dated August 18, 2011

- 197, X170-Pre-authorization was required, but not requested ofr this service per DWC Rule 134.600.

Issues

1. Did the requestor obtain preauthorization approval for the disputed physical therapy services?
   Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(p)(5)(A) the non-emergency healthcare that requires preauthorization includes: "(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
   (i) Modalities, both supervised and constant attendance;
   (ii) Therapeutic procedures, excluding work hardening and work conditioning."

   On April 22, 2011, the requestor obtained preauthorization approval for physical therapy for three visits per week for four weeks, codes 97110, 97112, and 97140.

   The respondent states in the position summary that "The billed charges for 05/04/11 for procedure code 97124 and 97032 were denied correctly as not pre-authorized. The only procedure codes approved by our Utilization Management department are 97110, 97112 and 97140."

   The Division finds that based upon the submitted documentation, the disputed physical therapy services, CPT codes 97124 and 97032 were not preauthorized per 28 Texas Administrative Code §134.600(p) or (q). As a result, reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	5/9/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.